Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROC HOUSTON, PA
SUITE 100
1200 BINZ
HOUSTON TX 77004

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-0428-02

MFDR Date Received
October 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...claim was denied based on the findings of a review organization as the service rendered not being medically necessary. Please be advised, that we extended treatment in good faith based on the expectation of payment as quoted and **pre-authorized as being medically necessary by your company.**"

Amount in Dispute: $1,798.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "At the time the pre-authorization notice was given to the provider, the carrier informed the provider that a PLN-11 was filed on 1/5/12 asserting that the compensable injury is limited to a right wrist sprain. The provided did not submit documentation that surgery was provided for a right wrist sprain... If the Division does not dismiss the provider's request for medical dispute resolution, then the carrier asserts that it is not liable for the provider's bill because treatment was provided for a non-compensable condition."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2012	25337	$1,798.16	$1,798.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - Note: Based on the findings of a review organization.
   - W9 – Unnecessary medical treatment based on peer review
   - Notes: – Reeval to bill #7215326. No Further payment warranted. MSN

Issues

1. Did the respondent raise the extent of injury issue during the medical bill review process?
2. Did the requestor obtain preauthorization for the disputed charge?
3. Does this requestor seek reimbursement for the professional services rendered in an ASC?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier raises the issue of extent of injury in the insurance carrier's position statement. The medical fee dispute referenced does not contain unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier did not notify the requestor of such issues in its explanation of benefits (EOB) responses during the medical billing process for this dispute. As a result, the disputed charges will be reviewed pursuant to 28 Texas Administrative Code §134.600.
2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   Review of the submitted documentation (preauthorization letter) issued by IMO Carrollton dated April 27, 2012 states in relevant part, "Requested Services: 25337-Reconstruction Distal Ulna or radioulnar joint, Pre-Authorized, authorization #: 46799, Certified Date of Service: 04/27/12 to 06/30/12."

   Review of the submitted documentation (CMS-1500 and medical documentation) support that the requestor provided CPT code 25337, as a result reimbursement is recommended per 28 Texas Administrative Code §134.203."
3. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor billed CPT code 25337 defined as "Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint."

   Review of the CMS-1500 box 31 indicates that the provider of service is Marcos V. Masson, M.D., the services were provided in an ASC, however the requestor disputes non-payment of the professional services provided in an ASC. Reimbursement is subject to 28 Texas Administrative Code §134.203. The division will calculate payment based on this rule.
4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   The division determined that reimbursement for CPT code 25337 provided in the ASC is $1,798.15; therefore the requestor is entitled to this amount.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,798.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,798.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 23, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).